Revised Draft – For Discussion and Adoption
(Contents and recommendations herein have not been approved by the Task Force)

IMPROVEMENT OF MANAGED CARE THROUGH COORDINATION AND INTEGRATION: CASE STUDY IN WOMEN'S HEALTH
FINDINGS AND RECOMMENTATIONS

I. BACKGROUND

Managed care promises not only to contain health care costs, but to improve efficiency and enhance health status and consumer satisfaction through a focus on prevention and better integration and coordination of care. While many managed care organizations have successfully contained costs and have increased availability and coverage of routine care and preventive services,[1] they have gotten mixed reviews from a consumer satisfaction perspective and have largely failed to achieve many promised improvements over traditional unmanaged fee for service ("indemnity") plans, particularly in the area of coordination of services. Utilization patterns continue to reflect the "fragmentation" that managed care seeks to correct. This paper explores some of the challenges managed care plans face in addressing women's health care needs, and suggests how coordination and integration in managed care could offer significant promise for improving health care for women.

II. MANAGED CARE - IDEALS AND CHALLENGES

As envisaged by the pioneering organizations, managed care offers the potential benefit of a coordinated system of health education, preventive care and treatment for illness. The overall premise is more proactive than that of traditional indemnity insurance; managed care plans seek to "optimize member health" rather than to simply treat members when they become sick. Experience to date has been mixed. Proponents of managed care point to success in the areas of cost savings, increased prevention and overall satisfaction levels similar to those of indemnity coverage, critics point to vocal consumer dissatisfaction with specific elements such as coverage limitations, curtailment of access to specialists, and broader use of non-physician providers (i.e. licensed health professionals, operating within their scope of practice).

Different health care systems, insurers and clinical authorities define and provide coverage for primary care in varying ways. The Institute of Medicine definition of primary care, "integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community[2] contrasts with the reality of most primary care provision in our current system.

Attempts to improve coordination and integration of care are appearing throughout the industry. One plan has developed an "adult primary care" model through which to coordinate more proactively the primary prevention and care needs of its adult member population. A similar focus on systematic management of chronic conditions in the member populations has become a common feature of managed care organizations through "disease management" programs which present a focal point within the plan for integration of multidisciplinary expertise around common chronic disease states.[3]

[1] Schauffler HH, Brown ER and Rice T, "The State of Health Insurance in California, 1996," University of CA at Berkeley School of Public Health and UCLA Center for Health Policy Research, January, 1997, p. 43.
[2] Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, Eds. Committee on the Future of Primary Care, Division of Health Care Services, Institute of Medicine, Washington, DC, National Academy Press: 1996.
[3] "Disease management, a term invented by the Boston Consulting Group in 1993, refers to a complete, systematic approach to treating chronic diseasesto reduce complications, overall utilization and cost.

III. WOMEN'S HEALTH– CHALLENGES FOR MANAGED CARE

Women's health provides a very powerful example of the failings, some of the successes and most importantly the potential of the managed care system to provide the benefits of integrated care.[4] While most observers agree that managed care plans have been very successful in making preventive care more broadly available,[5,6] consumers and critics contend that the system remains difficult to access and navigate. Several specific realities of the role of women in the health care system highlight both the challenges and potential for an integrated system of care:

- Women are the primary consumers of health care. They are responsible for coordinating care for most children and elders as well as for themselves. Enhancements to access through initiatives such as expansion of primary care sites, extended hours and telephone nurse advice lines can significantly affect their experience of the health care system.
- Fragmentation in clinical practice between the reproductive and non-reproductive elements of women's primary care is a well-documented problem. This fragmentation poses serious challenges to accessibility and accountability, and results in duplicative visits for many women.
- Women live longer than men and have a higher incidence of chronic diseases such as osteoporosis, arthritis, diabetes, depression, multiple sclerosis, lupus, urinary incontinence, thyroid disease and breast and gynecological cancers, yet women have been the subject of far less clinical investigation. For example, a number of NIH funded studies on the prevention of cardiovascular disease in the 70's and 80's excluded women, despite the fact that approximately the same number of American men and women die of heart disease each year.[7,8] The potential for improving clinical care for women through increased research, case management and chronic care programs is great.
- Policymakers, researchers and consumers have identified women's health as a significant issue and have delineated a number of areas in which plans could make specific improvements in both organization and practice. The subject of women's health is timely, and many have acknowledged that managed care organizations are well positioned to innovate in this area.

IV. INTEGRATIONAND COORDINATION IN WOMEN'S HEALTH

Integration and coordination challenges in women's health can be categorized or characterized in many ways. The following examples will explore challenges in coverage and benefit design, the consumer-provider relationship and access to/utilization of care.

A. Coverage and Coordination of Care

Women's health care services have historically been delivered in a fragmented manner, encouraged by several phenomena. Medical training and specialization has separated reproductive health specialties from primary care for women; public financing for reproductive health for low income women separates

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[4] The principles and potential benefits of integrated care may be applied widely, such as to mental and physical health care and to medical, surgical and pharmaceutical treatments.

[5] Reisinger, AL, "Health Insurance and Women's Access to Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 333.

[6] Schauffler HH, Brown ER and Rice T, "The State of Health Insurance in California, 1996," University of CA at Berkeley School of Public Health and UCLA Center for Health Policy Research, January, 1997, p. 43.

[7] Dickersin K and Schnaper L, "Reinventing Medical Research," in *Man Made Medicine: Women's Health, Public Policy and Reform*, Duke University Press, Durham: 1996, p. 59.

[8] Reidy Kelch D, "The Health of Older Women in California," California Women's Health Project, CEWAER, June 1996, p. 15. Note: A woman is twice as likely as a man to die within a few months of a heart attack.

reproductive health issues from other primary care; and politicization of reproductive services has promoted organizational segregation of providers and sites of care.[9]

Much of the backlash against the broader managed care system has been directed at plans' use of the primary care "gatekeeper." The majority of managed care plans employing the gatekeeper model have not convinced consumers that the primary care provider is performing a coordinating function – the overwhelming perception is that the gatekeeper is a barrier to choice and access. (See the Task Force's Physician-Patient Relationship paper).

A number of states introduced bills under which managed care consumers would have the right to self-refer to some specialists. This legislation reflects a very real concern on the part of consumers and presents interesting challenges for managed care organizations committed to pursuing coordinated and integrated care and controlling costs. The most prominent example highlights the fragmentation between reproductive and other health services for women. In the case of direct access to obstetrician/gynecologists, the legislation represents consumer demands for comprehensive primary care from organizations ostensibly organized to provide this care through coordination and integration of appropriate resources.

Benefit and Coverage Issues

Managed care has proven confusing to many consumers because of the broad variation in coverage and benefits. Results from the Commonwealth Fund survey indicated that many women (including between 7% and 15% of insured women depending on the specific service) do not seek basic, preventive care because they do not know whether their plan will pay for the services.[10] One out of three insured women surveyed reported that cost was a barrier to use of preventive services.[11] While HMOs help to reduce the cost barrier by minimizing copayments, lower income women who must cover copayments for multiple family members can face cost barriers even in an HMO setting.

Limitations on coverage for reproductive health services and mental health services represent two of the most significant barriers to improvement of the health status of women, and have been areas in which a great deal of the criticism of managed care has been focused. Demands for broader coverage of preventive services have often been countered, however, by lack of reliable outcomes measures and cost-effectiveness data for specific interventions. Development of a standard benefit package for *primary, preventive* care for women has been further confounded by leading authorities' variations in guidelines for screenings for services such as the Pap smear and clinical breast exam.[12]

B. Coordinated, Integrated Care – Provider Issues

The relationship between consumers and providers of care remains the primary relationship in the health care system. Integration of providers and the population includes elements as diverse as training of providers, recognition of the qualities and capabilities of a diversity of providers and relationship of providers with the health plans with which they contract. As noted earlier, women's health -- particularly women's primary care – presents some particular challenges for effective integration of

[9] Weisman C, "Women's Use of Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 21

[10] Reisinger, AL, "Health Insurance and Women's Access to Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 60.

[11] Wyn R, Brown ER and Yu H, "Women's Use of Preventive Health Services," in *Women's Health: The Commonwealth Fund Survey* Johns Hopkins University Press, Baltimore: 1996, p. 67.

[12] Reisinger, AL, "Health Insurance and Women's Access to Health Care," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 54.

providers and consumers. Studies show that women are more likely to receive primary care in a fragmented fashion (i.e. from both a generalist and a reproductive health specialist), to be dissatisfied with their provider and to request to switch physicians, usually over problems of communication.[13]

C. Access to and Utilization of Care

Time and Cost Constraints

Time demands and constraints result in significant access issues for women: a 1994 study indicated that 29 percent of women 65 and under had not received care they knew they needed in the prior year due to time constraints.[14] The availability of services at times and sites convenient to women is clearly an important factor in improving utilization of care. Cost of care is also a strong predictor of utilization. The same study indicated that one out of three insured women surveyed reported that cost (i.e. copays and/or deductibles) was a barrier to use of preventive services.[15]

Authorized Providers/Sites of Care

Because issues of reproductive health and social determinants of health (e.g. poverty and domestic violence) have been central to the development of the women's health movement, community health centers and reproductive health clinics have played an important role in providing services to women, and their important contributions as elements of a comprehensive primary care system have been noted by many. Selective contracting in managed care often overlooks these resources because they are seen as providers of free care or care duplicative of that offered by the plan's "provider panel." According to a 1994 GHAA/Kaiser Family Foundation survey only 23% of HMOs had a contract with a family planning or abortion clinic.[16] Over half of the remaining plans, however, indicated that they "intend to contract with such clinics in the future." Studies show that women and their families continue to rely on these providers of care even when they are insured, because of their proximity to their homes, cost, availability of services not covered under their insurance, and concerns about confidentiality. Under the current system this often results in cost-shifting to publicly-funded clinics.

V. CONCLUSION

Effective integration and coordination of health care presents a significant challenge for those working to improve the managed care system. It is clear that the issues of integration and coordination of care commonly discussed in the context of managed care need to be broadened if they are to truly reflect the issues the comprehensive health needs and health-seeking behavior patterns of women.

The "model" managed care plan would use demographic and encounter information to identify patients in need of specific care or services, conduct proactive outreach, offer preventive services with minimal cost sharing and consider whether and how the primary users of services – women – will access services once they are made available. Managed care organizations have begun to develop innovative approaches to the challenges of integration and coordination of care, and should be encouraged to work in partnership with consumers, clinicians and other advocates for women's health to incorporate the diverse and important needs of women into these improvements.

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[13] Kaplan SH, Sullivan LM, Spetter D, Dukes KA, Khan A, Greenfield S, "Gender and Patterns of Physician Patient Communication," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 86.
[14] Commonwealth – get cite.
[15] Wyn R, Brown ER and Yu H, "Women's Use of Preventive Health Services," in *Women's Health: The Commonwealth Fund Survey*, Johns Hopkins University Press, Baltimore: 1996, p. 67.
[16] Gold, RB and Richards CL, "Improving the Fit, Reproductive Health in Managed Care Settings," The Alan Guttmacher Institute, New York: 1996, p. 24.

Health care experts note that integration and coordination of care are very important attributes of an ideal health care delivery system, but they are difficult (if not impossible) to define in legislative language. Innovations in the areas of integration and coordination of care, therefore, are most likely to emerge from health care organizations working with member input to improve efficiency, effectiveness and member satisfaction.

VI. PRINCIPLES AND RECOMMENDATIONS

Specific recommendations for improvement of integration and coordination of women's health in the managed care system rests on several guiding principles.

Principles:

- The managed care system will only deliver on its promise of optimizing member health while containing health care costs if it operates upon a foundation of coordinated, integrated care.
- Comprehensive primary care addresses both biomedical and psychosocial factors in health and wellness.
- Provision of comprehensive primary care and coordinated care of chronic diseases will improve health status and outcomes.
- Womens' utilization of primary and preventive care is highly dependent on accessibility. As women are responsible for coordinating care for both themselves and most dependents, managed care organizations must not simply offer services, but must consider when, where and by whom services are being offered if they wish to achieve the full benefits of these interventions.

Recommendations:

The Task Force recommendations on consumer protection, consumer information, quality improvement and provider/consumer relationships are particularly relevant to reducing sociocultural and other barriers to health care for women. The following recommendations address coordination and integration of services as well as the need for more comprehensive health services for women, especially in the area of reproductive health.

1. Managed care organizations (MCOs) should be encouraged to coordinate and integrate care around the needs of members. Purchasers and accrediting organizations should work with advocacy groups to define member survey questions that measure the extent to which MCOs are effectively integrating and coordinating members' care, including services exclusive to women and incorporating measures of under and over-utilization. Because HEDIS measures are used widely by purchasers and consumers to assess health plan performance, the elements included strongly influence health plans' priorities in service delivery and quality improvement, and they serve as important leverage points for influencing both plan and provider behavior. MCOs should involve consumers and advocates in developing improved gender sensitive indicators for HEDIS and other quality improvement tools.

2. Recognizing that members, particularly women and adolescents, are likely to forego care because of issues of scheduling and confidentiality, managed care organizations should address these specifically as issues of access and should survey members to determine whether they feel that services are accessible and confidential.
3. When managed care organizations refer members to community-based clinics for services not available elsewhere within the plan (or recognize that many of their members are self-referring to

these facilities), they should be encouraged to provide an option that allows reimbursement for necessary primary and preventive care delivered at these sites.

4. Plans should be required by the state agency responsible for regulating managed care to provide information on coverage and benefits to all plan enrollees, not only to the primary plan subscriber, to ensure that those plan members covered as dependents are aware of the services available to them. The information should include full disclosure of limitations on reproductive health services and referrals.
5. The division between primary care and routine reproductive care for women results in underutilization of necessary preventive services, fragmentation of services, unnecessary duplication of services, inconvenience and cost for members and increased costs for insurers. To alleviate these problems:

(f) Primary care training programs should incorporate the full range of primary health needs of men and women, and should prepare practitioners or design practitioner teams to provide for the totality of these needs.

(b) Managed care organizations should ensure that primary care practitioners or teams made available to members are capable of providing the full range of necessary primary care services to avoid duplication that is costly to both plans and members. MCOs should be encouraged to require generalists who wish to provide primary care to women to demonstrate competency in basic aspects of gynecological care such as breast and pelvic exam, contraceptive management, and initial management of common gynecological problems.

(c) Women should be allowed direct access to their reproductive health care providers, be they physicians, nurse practitioners or other appropriately credentialed advanced practice professionals. The Task Force strongly urges plans to construct direct access arrangements in a manner that permits and encourages coordination and integration of services among an individual's health care providers (e.g. provisions should be made to ensure that providers agree upon division of tasks/treatment areas, communicate their findings and treatment advice with one another, and update and share patient records) while maintaining patient confidentiality.

3. The Task Force encourages collaboration between the public and private sectors on development of consistent standards and evidence-based, gender-specific practice guidelines.
4. The Task Force recommends that plans offer coverage of the full range of sexually transmitted disease (STD) and reproductive health services, including a full range of contraceptive devices/methods and a full range of standard medical practices to meet reproductive health needs. The state agency responsible for regulating managed care should require that descriptive plan information provided to potential and current enrollees include full disclosure of limitations on reproductive health services or referrals.

8. The Task Force recommends that plans offer coverage of the full range of pre- and post-natal services, including lactation support.